Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality Account

Appendices

2012-2013

Where EVERYONE Matters

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Annual Governance Statement 2012/13

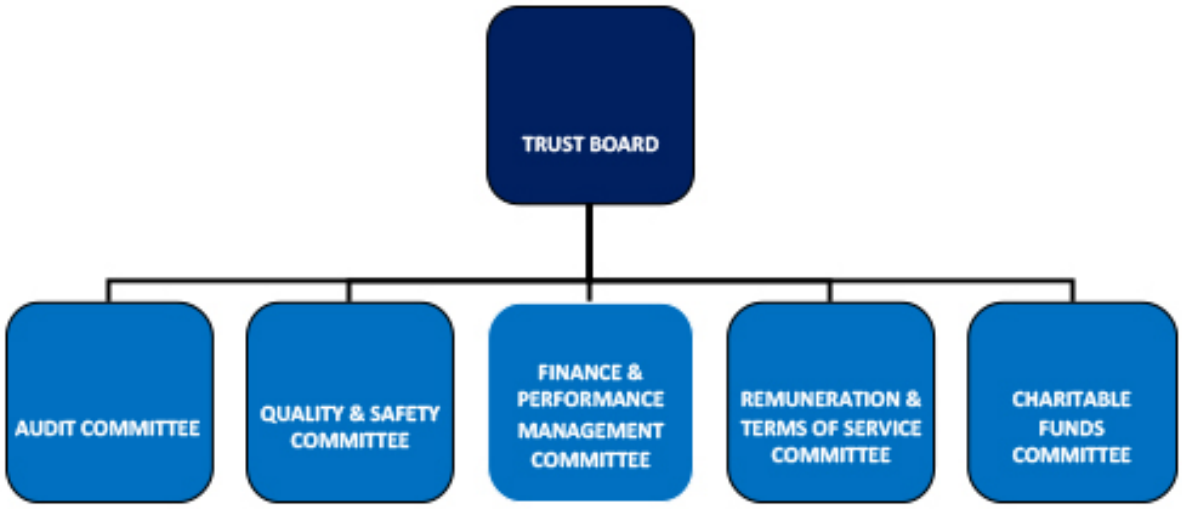
1. Scope of Responsibility

1.1 The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

1.2 In my role as Chief Executive of the Trust I fulfil my own responsibilities as its Accountable Officer in close association with the Chief Executive and senior officers of the National Trust Development Authority, the senior managers of the local Clinical Commissioning Group and the Council Leaders of the Local Authorities. Governance and risk issues are regularly discussed at a variety of Health Economy wide fora, including formal review meetings with the National Trust Development Authority, monthly meetings of Chief Executives and via the Partnership Board for the Health Economy-wide development plan, known as 'Right Care, Right Here'.

2. The Governance Framework of the Organisation

2.1 The organisation is led by the Trust Board, which in turn was supported in its duties during the year by five committees, as follows:



Audit Committee

Chair: Non–Executive Director

- Considers the annual plans and reports of both the External and Internal Auditors
- Provides an overview and advises the Board of Directors on the internal control arrangements put in place by the Trust Board
- Acts as the co-ordinator of all support documentation in relation to assurance to the Chief Executive for the sign off of the Annual Governance Statement
- Reviews all matters of internal control
- Reviews the annual work plan and monitors progress with the work of the Local Counter Fraud Specialist function
- Liaises with the Quality and Safety Committee as appropriate
- After due process of review recommends the adoption of the Annual Accounts to the Trust Board

Frequency: Five times a year, including a specific meeting to review and approve the annual accounts

Membership: Five Non-Executive directors (excluding the Chair). The Director of Finance has a standing invitation to attend and other Executives may attend when requested.

	17/5/12	7/6/12	13/9/12	6/12/12	14 & 28 /2/13
Gianjeet Hunjan (Ch)	✓	✓	✓	✓	✓
Roger Trotman	A	✓	A		
Sarindar Sahota	✓	✓	✓	✓	✓
Derek Alderson	A	A	✓		
Olwen Dutton	✓	✓	A	A	A
Phil Gayle	✓	✓	✓		
Clare Robinson				✓	✓
Harjinder Kang				✓	A

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

Quality & Safety Committee

Chair: Non –Executive Director

- Monitors and provides assurance to the Board that clinical services are appropriately delivered in terms of quality, effectiveness and safety
- Ensures that the Trust has effective and efficient arrangements in place for quality assessment, quality improvement and quality assurance
- Where quality and performance falls below acceptable standards, ensures that action is taken to bring it back in line with expectations, and to promote improvement and excellence
- Ensures that service user and carer perspectives on quality are at the heart of the Trust's quality assurance framework

Frequency: Monthly

Membership: Five Non-Executive Directors and six of the Executive Directors with specialist advisers in attendance when required

	24/5/12	19/7/12	20/9/12	19/10/12	22/11/12	14/12/12	25/1/13	21/2/13	21/3/13
Derek Alderson (Ch)	A	A							
Olwen Dutton (Ch)[#1]	✓	✓	✓	✓	✓	✓	A	✓	✓
Sarindar Sahota	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Samuda	A	A	A	A	A	✓	✓	✓	✓
Ganjeet Hunjan [#2]		A	✓	✓	✓	✓	✓	✓	A

Richard Lilford #3			A	A	✓	✓	✓	A	A
John Adler #4	✓	✓	✓	✓	A	✓			
Mike Sharon #5							✓	✓	✓
Robert White	✓	✓	A	A	✓	A	A	A	✓
Rachel Overfield	✓	✓	✓	A	✓	✓	✓	✓	✓
Rachel Barlow	✓	✓	✓	A	✓	✓	✓	✓	✓
Deva Situnayake #6	✓	✓							
Roger Steadman #7			✓	✓	✓	A	✓	✓	✓
Kam Dhami	✓	✓	✓	✓	✓	✓	✓	✓	✓

NOTES

#1 Assumed chair of Committee from July 2013
#2 Member of Committee from July 2013
#3 Commenced in post as a Non Executive Director from September 2012
#4 Departed the Trust from January 2013
#5 Acting CEO from January 2013
#6 Acting Medical Director until August 2012
#7 Commenced in post as Medical Director from August 2012

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

Finance and Performance Management Committee

Chair: Non –Executive Director

- Considers regular financial reports and forecasts, including prime statement of accounts and supporting analyses and forecasts
- Reviews the performance of the Trust's major clinical and corporate divisions and considers remedial action plans in the case of significant variances/deviations
- Reviews the annual financial plan and budget, prior to submission to the Trust Board for approval
- Monitors performance against external targets set by the Department of Health, Trust Development Authority, Commissioners and Monitor
- Monitors performance against a range of internally developed clinical, financial and operational indicators
- Considers plans and business cases in support of significant investment, prior to presentation to the Trust Board for approval

Frequency: Monthly

Membership: Three Non-Executive directors, CEO, Director of Finance and Chief Operating Officer

DIRECTOR	DATE											
	19/4/12	24/5/12	21/6/12	20/7/12	24/8/12	20/9/12	19/10/13	23/11/12	20/12/12	25/1/13	22/2/13	22/3/13
Roger Trotman (Ch)		✓	✓	✓	✓	✓	✓					
Clare Robinson (Ch)								✓	✓	✓	✓	✓
Richard Sanuda		A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gianjeet Hunjan		✓	✓	✓								
Phil Gayle		A	✓	A	✓	A	✓					
Harjinder Kang								✓	✓	✓	✓	✓
John Adler		✓	A	✓	✓	✓	✓	✓	✓			
Robert White		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mike Sharon										✓	✓	✓
Rachel Barlow		✓	✓	✓	A	✓	A	✓	✓	✓	✓	✓

NOTE:
NED attendance rationalised from July 2012 to restrict membership to three NEDs;
Chair ship changed from Mr Trotman to Ms Robinson from November 2012
Following his departure in December 2012, Mr Adler's seat on the Committee was given to Mr Sharon in his capacity as acting Chief Executive

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

Remuneration and Terms Of Service Committee

Chair: Non –Executive Director

- Sets the pay and conditions of senior managers
- Recommends the remuneration and terms and conditions of employment for any employees who are not subject to national terms and conditions of service
- Scrutinises and agree any termination payments made to the Chief Executive and Executive Directors
- Ensures the consistent application of the Trust policy on remuneration and terms and conditions of employment for the Chief Executive and the Executive Directors

Frequency: The committee meets as required

Membership: All Non-Executive Directors.

Attendance:

	31/5/12	2/12/12
Richard Samuda	✓	✓
Roger Trotman	✓	
Sarindar Sahota	✓	✓
Gianjeet Hunjan	✓	✓
Derek Alderson	A	
Richard Lilford		✓
Olwen Dutton	✓	✓
Phil Gayle	A	
Clare Robinson		✓
Harjinder Kang		✓

KEY:

✓	Attended
A	Apologies tendered
	Not in post or not required to attend

Charitable Funds Committee

Chair: Non –Executive Director

- Monitors the safeguarding of those assets donated or bequeathed in cash or other forms to the Trust's charitable funds
- Ensures as far as is practical that the expressed wishes of donors or benefactors are met in the deployment of funds.
- Monitors and reviews banking and audit arrangements
- Monitors the performance of the Trust's Charitable Funds portfolio
- Advises on the appointment of investment brokers

Frequency: Four times per year

Membership: All voting Directors are Trustees, however they are represented by six voting Board members. The HoCE and Head of Fundraising also attend

	17/5/12	13/9/12	6/12/12	14/2/13
Sarindar Sahota (Ch)	✓	✓	✓	✓
Richard Samuda	✓	A	A	✓
Roger Trotman	A	✓		
Gianjeet Hunjan	✓	✓		
Olwen Dutton	A	A		
Derek Alderson	A			
Clare Robinson			✓	✓
Phil Gayle	A	✓		
John Adler	✓	✓	✓	
Mike Sharon				✓
Robert White	✓	✓	A	✓
Rachel Overfield	A	A		✓
Rachel Barlow	A	A		
Roger Steadman		✓		

KEY:

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2.2 The Trust Board and its committees are administered by a Trust Secretary who maintains the Directors' Register of Interests and a register of attendance at meetings.

2.3 On an annual basis, the Trust Board is asked to consider and approve a proposed cycle of business for the forthcoming year, which is largely based on the best practice guidelines suggested in the Dr Foster publication, 'The Intelligent Board' and the National Leadership Council's report, 'The Healthy Board'. The reporting cycle is customised with items of local interest and significance to the Board, with matters being categorised into Quality, Safety and Governance; Strategy & Development; Performance Management; and Operational Management sections.

2.4 Integral to the preparation for the Trust's application for Foundation Trust status, is a number of Board assessments, development activities and opportunities. Much of this work has been facilitated by independent sources, most notably being the in-year assessments against the Board Governance Assurance Framework and Monitor's Quality Governance Framework. The assessments although largely focussed on the degree to which governance arrangements and quality is embedded into the organisation, also focus on the operation of the Board, including a comprehensive assessment of the skills and capabilities of Board members. The actions to address the recommendations arising from the assessments have been incorporated into an Integrated Development Plan. Given the thoroughness of the external scrutiny and the Board's close engagement with the work, a formal internal self-assessment has not been necessary this year. The FT readiness assessment work also included observations and feedback sessions on a series of Board and Committee meetings, a review of the Trust's Integrated Business Plan and a preparatory mock Board to Board meeting in advance of formal assessments. The outcome from these processes has been carefully considered by the Board and included within the Integrated Development Plan, including action as required. Finally, the Development Plan is monitored by the Board on a routine basis through the FT Programme Board.

2.5 In addition to the Integrated Development Plan, a plan specifically including matters pertaining to Board Development has been prepared. This incorporates both short term needs to focus on creating a cohesive team following the change in membership over recent months and longer term development requirements to develop the Board into a more effective and highly performing unit.

2.6 Within the last year there has been a refresh of the terms of reference of the Board Committees to bring them in line with best practice examples and to strengthen the role in providing the Board with the assurance it needs to satisfy itself that the organisation is operating legally, effectively and safely. The remit of the Quality & Safety Committee has been broadened to include a wider range of assurance matters, including the consideration of a comprehensive monthly report, which provides an update on the key activities and performance across the various dimensions of quality & safety. In addition to the minutes of the Committee meetings being presented to the Trust Board as a matter of course, a comprehensive verbal update is provided by the relevant sub-committee Chair following the most recent Committee meeting. Annual reports on the work of each of the Committees are also presented as part of the annual reporting cycle of the Trust Board.

2.7 A key area of interest for the Audit Committee during the year has been the process to assess the quality of data in respect of the Trust's performance against the national 18 week referral to treatment target. During the year the Committee has also considered the selection process and a revised specification for the provision of Internal Audit services to the Trust. The Committee took the opportunity to receive an update on the Trust's position in relation to the reference cost index (RCI) data and an analysis for the 2011-2012 financial year, where it was highlighted that the Trust RCI remained unchanged at 102 between 2010-2011 and 2011-2012, a period which included the incorporation of Sandwell's community services into the index.

2.8 The Board considers that the Trust has, throughout the 2012/13 reporting year, applied the principles and met the requirements of the Code of Governance. In summary, the Trust has an effective board of directors, which has taken collective responsibility for leading the organisation, exercising its statutory powers and setting the strategic direction of the Trust.

2.9 The Board's routine reporting includes a review of performance against the priorities of the Operating Framework, principally by measuring compliance against the NHS Performance Framework. The assessment reported the Trust to be classified as a 'Performing' organisation throughout the year.

3. Risk Assessment

3.1 The publicly held Trust Board meetings cover the full gamut of clinical, corporate and business risk and discuss and monitor the delivery of corporate objectives and the detail of the Assurance Framework.

3.2 The risk management process is an integral part of the Trust's business planning process and budget setting and performance review frameworks.

3.3 At a strategic level, risks are identified by the nominated directors against the Trust's strategic objectives and Annual Priorities. These identified risks provide information to support the Board Assurance Framework and where risks are identified as being 'serious', these are escalated to the Corporate Risk Register and monitored by the Trust Board and its delegated committees.

3.4 At an operational level, risks are maintained in appropriate local risk registers. Where a risk cannot be managed locally (requiring a supporting business case), has a major impact on service capability or Trust reputation or may result in major litigation, this will be presented for inclusion on the Corporate Risk Register.

3.5 Actions identified from risk assessments are mitigated at the appropriate level, and where actions require escalation, the risk will be escalated to the next tier of risk management.

3.6 Those risks that are presented for addition to the corporate risk register are presented monthly to the Trust Board. The Trust Board is asked to approve a proposal for the risk to be tolerated or treated.

3.7 The decision to treat a risk will be based on the actions required to mitigate that risk, its resource implications balanced against the possible financial penalty if the risk is realised. Every risk identified is backed up by a full risk assessment which covers the points above and an action plan to enable risk reduction, avoidance, transfer or elimination. The action plan defines the time for completion and who is responsible for carrying out the action. The status of the action plan will be monitored at intervals determined by the risk rating. Any difficulties in meeting the deadlines of the actions or in securing resources to enable mitigation are reported on the monthly risk register update that the Board receives.

3.8 New risks identified during the year have largely centred on the impact of the pause in the delivery of the Trust's bed configuration plan; the impact of the higher than planned operational pressures on the Trust's achievement of national performance targets; and the potential historic inaccuracy with reporting of the Trust's performance against the 18 week referral to treatment time target. All risks, together with their respective mitigation are included on the Trust's Corporate Risk Register, the summary of which is reported to the Trust Board on a monthly basis.

3.9 The Board, as part of the monthly Quality Report, receives a summary of the Care Quality Commission's Quality & Risk Profile (QRP). Overall the QRP shows the Trust as being at a low risk of non-compliance with the CQC's 16 essential standards of quality and safety, with the exception of Outcome 4 which relates to the 'care and welfare of people who use services'. The indicators forming this judgement and assessing the Trust's position as worse than the expected position or moving in that direction were reviewed and details were presented to the Quality & Safety Committee. The data sources include the Stroke Improvement National Audit Programme, PROMs (groin hernia surgery and knee replacement), the CQC A&E Survey and Dr Foster Intelligence.

3.10 Overall, the Trust remains fully compliant with the CQC essential standards of quality and safety. However within the year, the Sandwell Hospital was subjected to a responsive review of compliance by the CQC in connection with Outcomes 1, 4 and 14. The CQC assessed the Trust as meeting the standards at this site. Additionally, within the year, the Trust's positionwas assessed for compliance against a further set of outcomes including consent to care & treatment, assessing & monitoring the quality of service provision and complaints. The Trust was assessed as having shortfalls against a number of the standards and therefore an action plan was developed to address these matters. Good progress is being made with the delivery of the action plan, which is monitored on a monthly basis by the Quality & Safety Committee.

3.11 There have been no data security lapses that have warranted reporting to the Strategic Health Authority or the Information Commissioner's Office during the period.

3.12 Within the year, the Trust experienced a catastrophic hardware (disk) failure which resulted in a number of core systems including ICM and the Clinical Data Archive being unavailable to users between the 6th March 2013 and the 10th March 2013. None of the Trust's financial systems were affected. To prevent a reoccurrence of the situation, a threefold approach was undertaken to include: independent solution assurance; implementation of more robust operational monitoring of infrastructure and strengthened business continuity arrangements. The Trust Board was appraised of the situation and consequences of the IT failure at its Board meeting in March 2013, with a request for further detail and assurance on the measures being implemented to safeguard against a further incident.

4. The Risk & Control Framework

4.1 Sandwell and West Birmingham Hospitals NHS Trust has a comprehensive, trustwide system for managing risk, based on approved policies and strategies available on the Trust intranet.

4.2 The Trust has a Board approved Risk Management Strategy which identifies that the Chief Executive has overall responsibility for risk management within the Trust. The Chief Executive is supported with his responsibilities by the Director of Governance. All managers and clinicians accept the management of risks as one of their fundamental duties. Additionally the Strategy recognises that every member of staff must be committed to identifying and reducing risks. In order to achieve this the Trust promotes an environment of accountability to encourage staff at all levels to report when things go wrong, allowing open discussion to prevent their re-occurrence.

4.3 In Clinical Directorates, Clinical Directors, supported by Divisional Directors, General Managers and Heads of Nursing are responsible for managing risk. In all non-clinical directorates and departments, the appropriate Executive Director is responsible for managing risk through the chain of reporting.

4.4 The Trust has a designated Head of Risk Management within the Governance Directorate.

Board Assurance Framework

4.5 The Trust has a Board Assurance Framework which includes all key components required, including objectives, risks, controls, positive assurance, gaps in control and/or assurance and remedial action. In a recent review by Internal Audit, it was determined that Significant Assurance was provided by the Board Assurance Framework, with further areas for development identified to assist the Trust with continued improvement to the effectiveness of the processes in 2013/14.

4.6 The Board Assurance Framework is considered on a quarterly basis by the Trust Board and twice yearly by the Audit Committee.

4.7 The Board Assurance Framework informs the declarations made in this Governance Statement.

4.8 Gaps in controls and assurance of the management of the risks associated with the delivery of a number of the Trust's objectives were identified, however the Trust has taken remedial action to address them which is reported in the quarterly update of the Board Assurance Framework.

Quality Account

4.9 The Trust has in place robust processes to develop its annual Quality Account. The process and progress with developing the Quality Account is monitored by the Audit Committee.

Transformation Plan Quality Impact Assessment

4.10 A major piece of work within 2012/13 continued to be the development of the Transformation Plan, a five year view of how the Trust means to achieve the required cost savings within the period 2012/13 – 2016/17 in line with national efficiency requirements and local strategy. Quality Impact Assessment of schemes put forward as part of the 2013/14 element of the Transformation Plan was undertaken by the Chief Nurse and Medical Director. The assessments highlighted that there were some schemes where quality of care might be impacted and in these cases mitigation plans were produced, to minimise the effects of any risk realised. Those which remained a concern following the proposed mitigation were not approved as viable schemes. Responsibility for monitoring the actions has been devolved to divisions and where a risk is no longer controlled by those mitigating actions, the matter will be escalated.

NHSLA accreditation

4.11 Building on the successful accreditation against the NHSLA Risk Management general standards at Level 2 in February 2011, work continues to prepare for the reassessment against general standards in 2014/15. In February 2013, the Trust gained accreditation against CNST maternity standards at Level 2, with the Level 3 assessment planned for 2014.

Information security

3.17 Senior responsibility for information security, risks and incidents rests with the Chief Executive, as supported by the Interim Chief Information Officer. The Information Security Senior Responsible Owner (SRO) is supported by the Information Governance Manager and Head of Risk Management. The Information Governance Manager manages information security risk and incidents on a day to day basis and seeks support from the Head of Risk Management and SRO.

Regular reports are produced to identify information security incidents and the appropriate action planned to reduce the risk impact or likelihood of reoccurrence. These incidents are reviewed by the Information Governance Steering Committee to ensure appropriate action is taken.

Counterfraud and Whistleblowing

3.19 The Trust is supported through its Internal Audit function by a Counter Fraud service that reports routinely to the Audit Committee. The service, whose annual workplan is approved by the Audit Committee, is proactive in its role countering fraudulent activity within the Trust. A whistleblowing policy also exists and may be accessed by staff via the Trust's intranet, which provides the basis by which legitimate concerns can be fairly, effectively and speedily aired and responded to by the use of internal mechanisms. Work has been undertaken during the year to revise the policy and strengthen the processes for raising, logging and processing concerns. The policy advises that concerns should initially be raised at a local level with the facility for employees to register concerns directly with a designated Non Executive Director if necessary.

Alignment with the local context

4.20 The Trust is working closely with emerging Clinical Commissioning Groups to ensure alignment with their strategies and objectives these bodies have for improving the health, intervention, experience and outcomes for their patients within the overall context of the 'Right Care, Right Here' programme.

Internal Audit opinion

4.21 The Internal Auditor's Year End Report and opinion on the effectiveness of the system of internal control is commented on below. The internal auditor's overall opinion is that Significant Assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. As part of the auditor's opinion, concerns were highlighted with regard to the effectiveness of controls over data quality in relation to A&E indicators and 18 week referral to treatment reporting that led to the provision of only moderate assurance in both instances. Weaknesses with regard to theatre utilisation were also highlighted, which resulted in the provision of moderate assurance. The auditor did however advise that action plans had been agreed with management in relation to these moderate assurance areas and the implementation of those plans will be monitored.

The weighted opinion considers specific audit reviews and the level of assurance assigned to each. In addition to this, the overall arrangements put in place by the Board for conducting its own assessment of the system of internal control is reviewed. The principal tool for such an assessment is the Board Assurance Framework (BAF) and the internal auditor concluded that the BAF has been designed and is operating to meet the requirements of the 2012/13 Governance Statement and provides reasonable assurance that there is an effective system of internal control to manage the principal risks to the organisation.

The internal auditor concluded that in his view, taking account of the respective levels of assurance provided for each audit review, an assessment of the relevant weighting of each individual assignment and the extent to which agreed actions have been implemented, that the Trust has a generally sound system of internal control.

5. Review of Effectiveness

5.1 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. The overall level of assurance provided by the Head of Internal Audit Opinion for 2012/13 is Significant. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by reports and comments made by the external auditor, the Care Quality Commission and the NHS Litigation Authority, clinical auditors, accreditation bodies and peer reviews.

5.2 During the year, I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee, Finance & Performance Management Committee, Quality & Safety Committee, Clinical Quality Review Group, Quality Committees, Governance Board, Health & Safety Committee and the Adverse Events Committee.

5.3 The Trust Board is responsible for reviewing the effectiveness of internal control and the Board is supported in this by its corporate committees.

5.4 The Trust Board has receives a monthly update within the Quality Report from the Director of Infection Prevention and Control (a role currently within the remit of the Chief Nurse) on performance against national infection rate targets, together with effectiveness of structures in place to support infection control and measures to ensure continuous improvement in this area

5.5 Individual Executive Directors and managers are responsible for ensuring the adequacy and effectiveness of internal control within their sphere of responsibility.

5.6 Internal Audit carries out a continuous review of the internal control system and report the result of their reviews and recommendations for improvements in control to management and the Trust's Audit Committee.

5.7 Specific reviews have been undertaken by Internal Audit, External Audit, NHS Litigation Authority as well as various external bodies.

6. Significant control issues

6.1 Within the year, there were no data security breaches reported which warranted reporting to the Information Commissioners Office and Strategic Health Authority.

6.2 Two inspections by the Care Quality Commission which occurred within the year, one of which identified that there were concerns over compliance with a number of outcomes across City and Sandwell Hospitals, prompting the development of robust action plans to address the issues raised, progress with the delivery of which was given close oversight by the Quality & Safety Committee.

6.3 The Trust failed to meet the required performance against the Emergency Care 4-hour maximum wait target, being 92.55% for the year against a target of 95%. A robust winter plan for 2013 is in preparation intended to provide better resilience against increases in demand or reductions in supply. This is overseen by the Chief Executive, the Chief Nurse and Medical Director, alongside the Chief Operating Officer who is responsible for its execution.

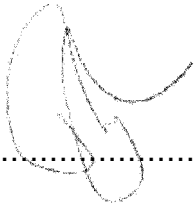
6.4 During the year, a data quality issue related to potential under reporting of 18 weeks referral to treatment pathways was identified. The Trust established a recovery and improvement programme to rectify the issues identified, the first stage of which validated the extent of the reporting problem. The second stage of the programme established an improvement

programme to resolve the issues identified, progress with which was reported routinely to the Trust Board and Audit Committee. The issue remains open and considerable work is needed in 2013/14 to establish stable systems. In light of these difficulties, the Trust has commissioned external advice on our data quality across all national performance indicators.

6.5 The Trust experienced a catastrophic hardware (disk) failure. To prevent a reoccurrence of the situation, a robust, multiple workstream approach was undertaken to include: independent solution assurance; implementation of more robust operational monitoring of infrastructure and strengthened business continuity arrangements. The Trust Board was appraised of the situation and consequences of the IT failure and continues to receive information to assure itself that safeguards are in place to prevent a reoccurrence.

7. Concluding remarks

7.1 With the exception of the internal control issues that I have outlined in this statement, my review confirms that Sandwell & West Birmingham Hospitals NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.



Signed ..... Chief Executive (On behalf of the Board)

Date .....

Appendix 2.

National Audits in which SWBH participated 2012/13

National Audits	Participated Yes /No	Percentage of eligible cases submitted
Women's & Child Health		
Neonatal intensive and special care (NNAP)	Yes	100%
Paediatric pneumonia (British Thoracic Society)	Yes	92%
Paediatric asthma (British Thoracic Society)	Yes	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	100%
Fever in Children (College of Emergency Medicine)	Yes	95%
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	100%
Hip, knee and ankle replacements (National Joint Registry)	Yes	93%
Renal Colic (College of Emergency Medicine)	Yes	100%
Severe trauma (Trauma Audit & Research Network)	Yes	46%
Long term conditions		
Diabetes (National Diabetes Audit) Adult	Yes	100%
Parkinson's disease (National Parkinson's Audit)	Yes	50%
Adult asthma (British Thoracic Society)	Yes	90%
Bronchiectasis (British Thoracic Society)	Yes	100%
Heart		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	100%
Heart Failure (Heart Failure Audit)	Yes	100%
Cardiac Rhythm Management Audit	Yes	100%
Acute stroke (SINAP /SSNAP)	Yes	TBD
Cardiac arrest (National Cardiac Arrest Audit)	Yes	100%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	77%

Coronary angioplasty (NICOR Adult Cardiac interventions audit)	Yes	100%
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	100%
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	100%
Head & neck cancer (DAHNO)	Yes	100%
Oesophago- gastric cancer (National O-G Cancer Audit)	Yes	100%
Blood and Transplant		
National Comparative Audit of Blood Transfusion	No	N/A
Potential donor audit (NHS Blood & Transplant)	Yes	100%
Older people		
Carotid interventions (Carotid Intervention Audit)	Yes	100%
Hip fracture (National Hip Fracture Database)	Yes	99%
National audit of dementia (NAD)	Yes	100%
Other		
Elective Surgery (National PROMs Programme)	Yes	76%
National Confidential Enquiries (Clinical Outcome Review Programmes)		
National Review of Asthma Deaths	Yes	67%
Medical & surgical programme - National Confidential Enquiry into Patient Outcome & Death (NCEPOD) The Trust participated in the following studies in 2011/12 - Subarachnoid Haemorrhage - Alcohol Related Liver Disease - Bariatric Surgery - Cardiac arrest procedures	Yes	 87.5% 100% 100% 100%

Appendix 3.

Actions taken in response to national clinical audits 2012/13

Report	Findings, Our Learning, & Our Actions
Provisional Patient Reported Outcome Measures (PROMs) in England **Audit description** An audit of outcomes reported by patients undergoing hip replacement, knee replacement, varicose vein surgery and surgery for inguinal hernia repair	**Key findings/learning** The provisional data for April 2010 – March 2011 shows little change in the Trust's average adjusted heath gain for all the four index procedures in comparison with the national average. In particular, it highlighted that improvements were required in relation to procedure specific scores for patients undergoing knee replacement. **Action** A number of steps have been taken to ensure that patients undergoing knee replacement receive appropriate information and support. The actions include incorporating information on PROMs into an existing information leaflet and to require all patients to attend the pre-operative Hip & Knee Club where information can be exchanged. In addition, posters have been distributed to local GP surgeries to support a campaign to improve referral information and information provided to patients.
National Adult Cardiac Surgery Audit Annual Report 2010-2011. **Audit description** The main objective of this audit is to collect information on activity, trends and outcomes in adult cardiac surgery in GB and Ireland. In the report data is presented for surgery performed in England and Wales	**Key findings/learning** The audit found that despite the increasing patient risk profiles, mortality for all cardiac surgery continues to fall. The report did not contain specific recommendations. It has been considered that no specific action is required as cardiac surgery is not performed in the Trust.
National Confidential Enquiry into Post-operative Outcomes and Death (NCEPOD) Report- 'A time to intervene?'	**Key findings/learning** The report indicated that for many acutely ill people better assessment and action early in their hospital admission may have led to interventions that may have prevented progression to cardio respiratory arrest or recognition that the person was dying and that attempted resuscitation would be inappropriate. PTO cont...

Report	Findings, Our Learning, & Our Actions
Audit description This was an audit conducted by the National Confidential Enquiry into Post-operative Outcomes and Death (NCEPOD) . It reviewed the care of patients who underwent cardiopulmonary resuscitation as the result of an in hospital cardio respiratory arrest	**Action** The recommendations contained in the report were reviewed and the following initial actions were identified. • The Resuscitation Team to consider ways of utilising the data collection tool used by NCEPOD for ongoing data capture • To review local Trust policies on resuscitation to incorporate the key recommendations • To ensure that all CPR attempts are reported through the Trusts incident reporting system and to ensure that there is a detailed review of the period prior to cardiac arrest to examine whether any antecedent factors were present.
National Neonatal Audit Programme – Annual Report 2011 **Audit description** The key aims of the audit are: • To assess whether babies requiring neonatal care received consistent care across England in relation to the audit questions; • To identify areas for improvement in neonatal units in relation to delivery and outcomes of care; • To provide a mechanism for ensuring consistent high quality care in neonatal services	**Key findings/learning** The audit showed that compliance was below the national average for antenatal steroid rates and for the proportion of babies discharged from the neonatal unit receiving their mothers milk. The recorded antenatal steroid rate has improved compared to the previous year but was lower than the national average. It was considered that this was due in part to inadequate recording on the BADGER database system. Data from BADGER feeds into the national report. **Action** To improve the compliance, the neonatal admission summary document is now entered directly onto BADGER which will improve the recording of steroid use, and it is planned to increase the number of staff trained to counsel mothers with regard to breast feeding.
National Diabetes Inpatient Audit- 2011 Report **Audit description** The National Diabetes Inpatient Audit (NaDIA) is commissioned by the Healthcare Quality	**Key findings/learning** Overall the audit found that despite the commitment of diabetes teams there had been little change in diabetes staffing with inadequate provision of inpatient specialist diabetes care at many sites and especially in the provision of multidisciplinary foot care PTO cont...

Report	Findings, Our Learning, & Our Actions
Improvement Partnership (HQIP) It is a snapshot audit of diabetes inpatient care in England and Wales. The aims of the audit include finding the answers to the following questions:- • Did diabetes management minimise the risk of avoidable complications? • Did harm result from the inpatient stay? • Was patient experience of the inpatient stay favourable?	teams. As a result, support and investment will be required for under resourced teams if they are to improve care. Locally, a review of the report highlighted the need to enhance primary prevention strategies across the health economy and for all stakeholders to continue to work to develop services. In addition, local audit findings highlighted some areas where improvements in performance against several quality markers were required, particularly at Sandwell Hospital. In particular improvements in aspects of medicines management and in the education and training of staff in diabetes were required. **Action** The actions identified to improve education and training included considering making the NHS Diabetes e-learning module on the safe administration of insulin required training for relevant staff. To enhance medicines management a series rolling audits of insulin prescribing, storage and administration of insulin and other diabetes medications were commenced.
The National Bowel Cancer Audit 2012 Report **Audit description** The audit is run in conjunction with the Association of Coloproctology of Great Britain and Ireland and is designed to assess whether patients with colorectal cancer receive the appropriate treatment for their cancer when it is first discovered.	**Key findings/learning** Data for the Trust indicated a higher than expected rate for 30 day and 90 day post-operative mortality. An investigation has indicated that in many cases the risk profiling could have been influenced by the poor recording of patient's pre-operative health status. In particular, the ASA status (grading of co-morbidity) for the patients was understated in many cases. **Action** To ensure that data to be submitted to the audit is reviewed and discussed prior to submission to ensure that it is as accurate and complete as possible.

Report	Findings, Our Learning, & Our Actions
Epilepsy 12 – National Report 2012 **Audit description** Epilepsy12 is a UK-wide multicentre collaborative audit which measured systematically the quality of health care for childhood epilepsies. The '12' refers to the 12 measures of quality applied to the first 12 months of care after the initial paediatric assessment. Care was compared to National Institute of Clinical Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN) Epilepsies guideline recommendations.1,2	**Key findings/learning** Nationally, the results showed that improvements are needed for many aspects of service delivery and professional input, including diagnosis, investigation, treatment and communication. In particular, there had been a considerable lack of progress in the availability of children's epilepsy specialist nurses to provide support and advice to children and their families. In addition, it was recommended that where there was evidence of a diagnoses of epilepsy being made and then subsequently withdrawn, this should be investigated to understand the reasons behind this. **Action** Although the Trust was not an outlier in the audit, it was identified that increased paediatric epilepsy specialist nurse input was needed particularly for West Birmingham patients and therefore a business case for increased resources was needed be made to commissioners. In order to help to ensure a correct diagnosis of epilepsy, the training provided for junior doctors has been adapted to include epileptic and non epileptic scenario based teaching.
National Audit of Percutaneous Coronary Interventional Procedures Report 2011 **Audit description** The National audit of PCI is managed by the National Institute for Cardiovascular Outcomes Research (NICOR). The audit is one of six national cardiac clinical audits managed by NICOR, part of the National Centre for Cardiovascular Prevention and Outcomes at University College London. The purpose of NICOR is to provide information on quality and outcome of care provided to people with heart disease and to provide technical infrastructure, project management and statistical support for the national cardiac audits and clinical registries	**Key findings/learning** Nationally, there is evidence that suggests improved outcomes for patients being treated in higher volume PCI centres, particularly those that perform at least 400 procedures per annum (pa). The overall rate of death before discharge from hospital following PCI has gradually risen over the past few years. This is due to a change in case mix. The report did not contain specific recommendations and it has been determined that no specific actions are required.

Report	Findings, Our Learning, & Our Actions
Myocardial Ischaemia National Audit Project – Eleventh National Public Report **Audit description** It presents analyses from all hospitals and ambulance services, in England, Wales and Belfast, that provided care for patients with suspected heart attack between April 2011 and March 2012 (2011/12).	**Key findings/learning** The purpose of the report is to inform the public about the quality of local care for heart attack patients. For the first time data was presented on primary PCI within 120 minutes of calling for help. **Action** It has been determined that action is required to further improve the door to balloon times for patients. As a result, the possibility of implementing a system of direct access to the catheter lab is now being explored.
National Heavy Menstrual Bleeding Audit – Second Annual Report 2012 **Audit description** Eligible women who had consented to participate in the audit were asked to complete a questionnaire at their first gynaecology outpatient visit (the baseline questionnaire). Questions included were on the severity of the condition, the impact its symptoms had on quality of life and the treatments they had received in primary care. In this report the patient-reported outcomes from the baseline questionnaire are described.	**Key findings/learning** The report was considered by the audit lead and it was determined that no specific action was required. The report did not contain any recommendations and therefore there were no specific implications for the service.
National Confidential Enquiry into Suicide and Homicide for people with Mental illness - Annual Report 2012 **Audit description** The enquiry examines all incidences of suicide and homicide by people in contact with mental health services in the UK. They also examine all cases of sudden death in the psychiatric in- patent population.	**Key findings/learning** The report has been considered and although there are no specific recommendations requiring action, the Trust continues to ensure that its systems are robust in order to assess the level of suicide risk and to take appropriate action. For example, a Therapeutic Observation Policy which indicates the level of staff supervision dependent on the level of risk, and a tool for reviewing environmental risk to patients who are at risk of suicide, are in place.

Report	Findings, Our Learning, & Our Actions
British Isles Network of Congenital Anomaly Registers - Congenital Anomaly Statistics 2010. **Audit description** The report which was published on 02/08/12, collates data from six regional congenital anomaly registers, which together cover 35% of the births in England and Wales, to provide an estimate of the prevalence of congenital anomalies nationally.	**Key findings/learning** The report has been considered by the relevant Directorate and discussed with neonatal colleagues. The report does not contain any specific recommendations. As a result, it has been indicated that no changes are required to be made to local practice in light of the report.
National Joint Registry (NJR) 9th Annual Report 2012 **Audit description** The NJR aims to improve patient safety and clinical outcomes by providing information to all those involved in the management and delivery of joint replacement surgery, and to patients. This is achieved by collecting data in order to monitor the effectiveness of hip, knee and ankle replacement surgery and prosthetic implants.	**Key findings/learning** The report has been considered by the service lead clinician and no specific action was determined. The recommendations in the report concerned ensuring that there are local systems in place for the monitoring of performance. These monitoring arrangements are already in place and demonstrate good compliance with the requirements.
National Confidential Enquiry in Patient Outcome and Death (NCEPOD) Report – 'Too Leaner a Service? **Audit description** The report was published on 18/12/12 and contained the findings arising from a review of the care of patients who underwent bariatric surgery.	**Key findings/learning** The report was considered not to be directly relevant to the Trust as bariatric surgery is not performed within in the organisation.

Appendix 4.

Actions taken in response to local clinical audits

The actions are a brief summary, and not intended to give the full details.

Audit Topic	Actions Identified
WHO Checklist Compliance Audit **Audit description** To assess the compliance with the "Five Steps to Safer Surgery" in the Trust. This includes use of the Surgical Safety Checklist.	**Key findings/learning** Results have shown that there is good compliance with the completion of the three sections on the Surgical Safety Checklist. **Action** Further work is required to ensure that a debrief session is recorded at the end of theatre lists. To address this, a series of observational audits have been conducted in theatres to provide feedback to staff and with the aim of improving compliance with all five steps, including debriefing at the end of a list.
An audit of pre-operative investigations of patients undergoing surgery for breast cancer. **Audit description** A retrospective audit all pre operative investigations for patients undergoing breast surgery for cancer in a 12 month period to determine the cost effectiveness and relevance of routinely performed pre operative tests.	**Key findings/learning** The audit found that the majority of tests that were performed were normal and so changes required to investigations arising from as a result of abnormal pre-op tests were not identified. **Action** Based on the findings it was recommended to stop all pre-op tests for patients with breast cancer who were under the age of 50 who were without significant co-morbidity, and to create a local guideline/algorithm for the pre assessment of patients undergoing breast surgery.
An audit of the use of the Paediatric Early Warning Scoring System (PEWS) **Audit description** An audit to evaluate the use of the PEWS system on the paediatric wards.	**Key findings/learning** The audit found that in the sample examined, the vast majority of cases (85%) the PEWS scores were added appropriately and that the action taken in response was appropriate in 93% of cases. Despite this, the recoding of specific physiological parameters could be improved e.g. respiratory distress. **Action** To take steps to further improve the recording of physiological parameters on the PEWS chart and to undertake a further audit with an increased focus on HDU cases to confirm whether the escalation tool functions effectively.

Audit Topic	Actions Identified
Re-audit of complications following TRUS prostatic biopsy **Audit description** An audit of infection rates following TRUS-guided prostatic biopsy with particular emphasis on admission rate due to sepsis	**Key findings/learning** The audit found that the incidence of urosepsis was low with only 1 patient requiring admission into hospital for intravenous antibiotics in the 12 month audit period. A further 3 pateint presented to the hospital with urinary tract infections which were treated on an outpatient basis. As a result, it was concluded that the current antibiotic protocol should be continued. **Action** It was agreed to continue to the audit to ensure that the urosepsis rate remains low and to confirm the optimal antibiotic protocol.
Nasogastric tube audit **Audit description** An audit to assess compliance with the NPSA Patient Safety Alert (PSA002) – 'Reducing the harm caused by misplaced nasogastric feeding tubes'.	**Key findings/learning** The audit found that only a small number of junior doctors at the time of the audit had accessed the e-learning module for safe NGT insertion and therefore this need to be improved. In addition, the audit found that a number of NG tubes were being placed after 2100hrs and that clearer documentation of the reasoning behind insertions was required. **Action** Action to improve compliance have included making the completion of e-learning module for junior doctors mandatory, and also implementing a programme of quarterly audits to monitor compliance with the requirements going forward.
Emergency Department Audits **Audit description** A series of specific audits covering the use of proformas to be used with patients presenting with a head Injury, alcohol intoxication or a headache.	**Key findings/learning** The spot check audits continue to show good compliance at greater than 90%. **Action** Instances of non compliance are addressed. Reminders are issued and training is provided if required.

Audit Topic	Actions Identified
An audit to assess Directorate compliance with the Trust policy on the management of clinical diagnostic tests. **Audit description** An audit to assess the compliance with the NPSA Safer Practice Notice 16 – 'Early identification of failure to act on radiological imaging reports'. It included assessing compliance with local Directorate protocols setting out how clinical diagnostic tests are to be managed in their Directorate.	The audit also found that many Directorate protocols required to be revisited in order to meet all of the required standards and that these were not embedded in practice. Electronic Results Acknowledgement (eRA) was developed and implemented to provide real – time access and acknowledgement functionality. The audit found that 50% of radiology reports were acknowledged electronically, with the remainder following a paper based system. **Action** • The actions determined to improve compliance included:- • Requiring Directorates to revisit their local policies for the management of clinical diagnostic tests; • To develop a communication plan to re-communicate the key messages around the safe management of the results of radiological imaging; • To take steps to improve the usage of eRA in the Emergency Departments.
Healthcare Records Audit **Audit description** An annual audit of healthcare records to measure compliance with local policy and to address risk management standards as set out by the NHS Litigation Authority.	**Key findings/learning** The results highlighted that there were aspects of record keeping that required to be improved. These included improving the physical quality of the healthcare record. Overall, the compliance with the 'basics of record keeping' standards had shown some improvement when compared to the previous year. **Action** Specific actions that were identified included:- • Introducing monthly monitoring audits to assess compliance with standards and to ensure timely feedback to Directorates; • To raise the awareness of the essential quality standards by recirculating the leaflet previously sent out with payslips.

Audit Topic	Actions Identified
Audits of basic care **Audit description** A composite of audits conducted biannually that includes assessing compliance with the Essences of care contained in the Essence of Care – "getting the basics right", (NHS Plan 2000). The audit assessed the quality of record keeping and whether the following assessments had been conducted. • Communication needs • Pain • Bladder and bowel care • Personal hygiene needs • Mental health needs • Hydration and nutrition • Tissue viability • Falls risk • Moving and handling needs • Oral hygiene needs • Infection prevention and control	**Key findings/learning** The findings highlighted that there had been improvements in the assessment of personal hygiene/ self- care and oral hygiene. This was considered to be as a direct consequence of the implementation of care rounds and new clinical documentation. In addition, compliance with mental health assessments had also improved in comparison with the previous audit and also in the completion of pressure ulcer and falls risk assessments remained high with 97% completion rates for both. **Action** All wards and Divisions are presented with performance reports and action plans are required to be developed to address specific areas of unsatisfactory performance. It was identified that further work is required to ensure that improvements are also made in record keeping. In addition, a review of the audit tools was identified and this would be conducted through a series of workshops. This would then be informed by the feedback from staff on their experience of using the tools.
Audit of Antenatal Steroid Compliance **Audit description** The National Neonatal Programme Audit Report 2010 (published July 11) had indicated that, according to data extracted from the Badger database, the percentage of eligible mothers receiving any dose of steroids was below the national average. It was considered that this in part was due to poor recording of this data onto the Badger System. To confirm this , an audit of casenotes was conducted to establish the level of compliance. The audit examined antenatal steroid use for babies less than 34 weeks gestation.	**Key findings/learning** The audit confirmed that the inputs into the BADGER system needed to be improved. The compliance with antenatal steroid administration in the sample audited was 81.8% across the Trust. This was better than that recorded on the Badger system for same period. **Action** The audit recommended a number of actions to improve the accuracy of the data submitted . These included inputting the neonatal admission summary directly onto the BADGER database and to ensure that this aspect is covered in the Neonatal Induction programme. In addition, to review local guidelines to ensure that they are clear about the administration of steroids.

Audit Topic	Actions Identified
Management of urodynamic stress incontinence in City and Sandwell hospitals. **Audit description** The aim of the audit was to assess whether the management of urodynamic stress incontinence in City and Sandwell Hospitals conforms to local Trust guidance.	**Key findings/learning** The audit found that although the documentation of the clinical assessment was good, there was poor documentaion of whether:- • general lifestyle advice had been supplied; • a bladder diary had been assessed; • pelvic floor physiotherapy had occured. (A trial of supervised pelvic floor muscle training of at least 3 months' duration should be offered to all women with stress incontinence as first-line treatment) **Action** To introduce a standardised Urogynaecology proforma to be used during clinical assessment (History, Examination, Investigations and Management Plan) in all patients with urogynaecological symtoms. To conduct a reaudit in January 2014
A retrospective audit of the quality ratings for intra-oral radiographs taken within the Oral Surgery Department. **Audit description** The main objective of the audit was to examine the effectiveness of the current radiograph quality assurance system used in oral surgery to assesses compliance with National Radiological Protection Board (NRPB) Guidelines for the rating of film quality i.e. that these are taken well and are of diagnostic value. Radiographs were independently reviewed and rated for image quality.	**Key findings/learning** Incomplete documentation was found to be present in a third of cases. A third of radiographs were re-rated on the second independent review. **Actions** To provide educational sessions for clinicians and radiography trained nurses on the NRPB rating system. This will inciude development of a handbook with an explanation of subjective QA ratings and pictorial examples of common errors. In addition, to develop a clearer radiology reporting form to support the ongoing quality assurance process and for reassessment of the system in August 2013.
Mortality audits **Audit description** Audits of specific diagnostic groups to determine whether any quality of care issues are present	**Key findings/learning** The audits have identified areas where care processes and the recording of care can be enhanced. In particular, greater accuracy in death certification and clinical coding have been identified as key work streams. In addition, further work is required to ensure compliance with best practice in the management of sepsis.

Audit Topic	Actions Identified
	Action To help to improve the accuracy of death certification, a draft educational package has been developed. This will be utilised in the training provided for Junior Doctors that will commence from March 13. To enhance the management of sepsis, the Sepsis Committee is spearheading the continued implementation and audit of the 'Sepsis Six Care Bundle', and aspects of sepsis management are to be included as a Commissioning for Quality and Innovation (CQUIN) target for 2013/14.
An audit of ultrasound accuracy in predicting axillary lymph node positive disease in breast cancer **Audit description** The purpose of the audit was to determine a baseline predictive value for preoperative axillary ultrasound in the detection of positive lymph nodes in breast cancer and to compare this with published data.	**Key findings/learning** The audit found that the sensitivity and specificity of pre-operative axillary utrasound was in line with publshed data. In addition, that in some cases it was not documented in the records as to whether the patient had received an axillary ultrasound scan. **Action** To use the findings as a baseline for further audit and to take steps to ensure that the occurrence of an axillary ultrasound scan is documented in all cases.
Re-audit of the diagnosis and management of gastroenteritis in children under 5. **Audit description** The main purpose of the audit was to review practice against NICE Clinical Guideline 84 (Diarrhoea ans vomiting in children). Children at risk of dehydration should be offered oral replacement supplements (ORS)	**Key findings/learning** All patients identified with red flags indicating that IV fluids should be given, received an infusion, however, not all patients who were at risk of dehydration were offered ORS. **Action** • To develop and implement a checklist for the management and discharge of patients presenting with diarrhoea and vomiting. • To raise the profile of current guidelines further through publishing information on the assessment of dehydration in ward areas. • To reaudit in 2013

Audit Topic	Actions Identified
An audit of adherence to the Trusts antibiotic guidelines on the Medical Assessment Unit. **Audit description** The aim of the audit was to establish whether antibiotic prescribing practice on the MAU was appropriate and in accordance with Trust guidelines.	**Key findings/learning** Overall, the audit findings indicated that adherence to the Trusts antimicrobial guidelines on the unit at this time was below the expected level. There were examples where the indications for the antibiotic use were not clearly documented, and also that the duration for antibiotic treatment was not recorded. **Action** • Specific actions identified have included:- • Increasing the frequency of training in antimicrobial stewardship for medical staff at all levels; • Considering adding an antibiotics section to the admission clerking proforma to enhance compliance with the key requirements; • To reaudit 6 months after the implementation of changes to improve practice.
An audit to measure compliance with NICE Clinical Guideline 101 (Chronic Obstructive Pulmonary Disease) – Pulmonary rehabilitation component **Audit description** An audit to assess compliance with the requirement that pulmonary rehabilitation should be made available to all appropriate people with COPD, including those who have had a recent hospitalisation for an acute exacerbation. Pulmonary rehabilitation should be offered to all patients who consider themselves functionally disabled by COPD (usually MRC grade 3 and above).	**Key findings/learning** The audit found that only 40% of patients referred to the Community Respiratory Service during the audit period were offered rehabilitation, but that it was not possible to determine clearly what percentage of these patients had a MRC scale of 3 or above. In addition the findings indiacted that 51% of patients who were offered rehabilitation actually partcipated in it, and that 71% of those who partcipated in the programme actually completed it. **Action** The actions identified included:- • To take steps to improve how staff members communicate about the rehabilitation programme to patients e.g. about the benefits of the programme. • Community Respiratory Team to provide the British Lung Foundation leaflet to patients in addition to a DVD already in use. • To discuss the findings with the whole respiratory team to ensure appropriate referrals for rehabiliation are made including from an acute hospital admission.

Appendix 5- Auditor's Statement of Limited Liability

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent assurance engagement in respect of Sandwell and West Birmingham Hospitals NHS Trust's Quality Account for the year ended 31 March 2013 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death
- Percentage of patients readmitted within 28 days.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2012 to June 2013;
- papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;

- the latest national patient survey dated 21/02/2013;
- the latest national staff survey dated 15/02/2013;
- the Head of Internal Audit's annual opinion over the trust's control environment for 2012/13
- the annual governance statement dated 06/06/2013;
- Care Quality Commission quality and risk profiles reported to the Board December 2012; and
- the results of the Payment by Results coding review dated May 2013.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Sandwell & West Birmingham Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Sandwell & West Birmingham Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Sandwell & West Birmingham Hospitals NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP

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28 June 2013